

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041965

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10054

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED OCT 17 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		c. CITY OR TOWN ST. LOUIS 2851 NORWOOD	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp #1		d. STREET ADDRESS (If outside, give location) 2851 NORWOOD	
3. NAME OF DECEASED (Type or print) First Middle Last Melvin Robinson		4. DATE OF DEATH Month Day Year 10 6 63	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/7/63
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (City and state or country) ST. LOUIS, MO		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME JESSIE ROBINSON	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT ST. LOUIS CITY HOSP. #1.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningoencephalitis, acute, Viral</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Herpetic Dermatitis</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 0823	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 9/14/63 to 10/6/63 and last saw her alive on 10/6/63 Death occurred at 9:25 am on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) H.D.	
22b. ADDRESS 1515 Lafayette Ave		22c. DATE SIGNED 10/6/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-31-63		23b. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23c. LOCATION (City, town, or county) St. Louis, Mo.		23d. DATE RECD. BY LOCAL REG. OCT 10 1963	
24. FUNERAL DIRECTOR MO. ANATOMICAL BOARD, 1402 S. GRAND		25. REGISTRAR'S SIGNATURE R. Smith, M.D.	

KHATOON

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

CHICAGO-CAN

157001

8001

818

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

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